DESERT STATE DENTAL ANESTHESIA, LLC

Patient Registration

Patient Name: _____

Mailing Address:_____ City: _____Zip: _____

Telephone: daytime:_____ evening: _____

Parents' or legal guardians' names:_____

Patient Medical History

Gender: M F Weight: _____lbs. Date of Birth: _____/_____/_____

Has the **patient** ever had or been diagnosed with**: (circle all that apply)**

Asthma Fainting Spells Heart Murmur Heart Surgery Irregular Heartbeat	Seizures Sleep Apnea Diabetes Hyperthyroid Hypothyroid	Bleeding Disorder Down Syndrome, Other Syndrome other:_____ _____	Cerebral Palsy Cystic Fibrosis Hemophilia Mastocytosis	Malignant Hyperthermia (patient or family history) Muscular Disease Muscular Dystrophy Sickle Cell Anemia Tracheal Malacia

Is the **patient** under the care of any of the following? (**please circle**)

cardiologist, endocrinologist, geneticist, hematologist, neurologist, oncologist, pulmonologist, pediatrician, none

Please list any previous surgeries:_____

Please list any allergies (medicine, food, latex, etc): _____

Please list any current medications including inhalers:_____

Does the patient use Albuterol or Xopenex? _____ If yes, how often? _____

Anesthesia Agreement and Consent

Patient safety is the anesthesiologist's primary concern. Serious complications are not to be expected. However, there are certain risks that are inherent to the administration of anesthesia. These include but are not limited to: bruising or tenderness at the IV or IM (shot) site, soreness of the mouth, lips, nose or throat, temporary dizziness, blurred vision, weakness and impaired judgment, post- operative drowsiness, nausea and/or vomiting. **Extremely rare** complications of general anesthesia such as anaphylaxis, malignant hyperthermia, cardiac dysrhythmia or arrest, and vomiting with aspiration would require emergency transport and hospitalization.

I have had the risks and potential complications as well as the anesthetic plan explained to me. I understand that I am responsible for the costs of treating any potential complications that require additional medical treatment. I have had all of my questions answered to my satisfaction and agree to proceed with the anesthetic.

I acknowledge the pre-operative fasting regulations and will ensure that they are followed. **The patient will have nothing to eat or drink (nothing by mouth) after 11 PM the night before the appointment. Even small amounts of food given before anesthesia may result in serious life threatening complications requiring emergency services and hospitalization.** These restrictions are for the safety of the patient.

HIPAA Privacy Statement

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information.

I understand that this information can and will be used to: **1)** Conduct, plan, and direct treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly. **2)** Obtain payment from third-party payers.

_____ _____ _____

Name of Parent or Guardian Signature Date